Clinical Notebook

Decision Making Guidelines for the Use of Direct Therapeutic Exposure in the Treatment of Post-Traumatic Stress Disorder

Brett T. Litz, Dudley D. Blake, Robert G. Gerardi and Terence M. Keane
Boston Veterans Administration Medical Center
and Tufts University School of Medicine

Systematic therapeutic processing of traumatic cues utilizing either flooding or implosive therapy (i.e., Direct Therapeutic Exposure (DTE), Boudewyns & Shipley, 1983) has been hypothesized as the treatment of choice for patients with Post-Traumatic Stress Disorder (PTSD) (Fairbank & Brown, 1987; Keane, Fairbank, Caddell, Zimering, & Bender, 1985). Research supporting this thesis has been obtained from single case (e.g., Fairbank & Keane, 1982; Keane & Kaloupek, 1982) as well as group outcome studies (e.g., Keane, Fairbank, Caddell & Zimering, 1989). Overall these data demonstrate that DTE can lead to considerable improvement in traumatized patients. However, it is likely that even highly trained behavioral clinicians do not use DTE with all of their PTSD patients. Furthermore, it is not widely known what criteria are used in deciding to use DTE.

Behavior therapists are frequently asked to make judgments about treatment for PTSD patients who present with varied symptom pictures and levels of impairment (Fairbank, 1989). A particular PTSD patient may be judged unsuitable for DTE for a number of reasons (e.g., therapist's resources, the physical health of the patient, patient's ability to meet the boundary conditions of the technique, the presence of concurrent psychiatric diagnoses, etc.). Judgments about whether to use DTE in the treatment of PTSD are typically based on the therapist's implicit model for change which takes into account these interrelated variables. Ideally, however, judgments about choice of DTE for an individual PTSD patient should be based on an empirical and explicit decision making model. Thus, the purpose of the present study was to identify the factors that expert clinicians consider in their judgments about the appropriateness of DTE as a treatment for PTSD. The goal was to establish practical guidelines about the suitability of DTE for PTSD patients.

As a first step toward establishing rules for judging the appropriateness of DTE, a 23 item questionnaire[1] was designed to assess various aspects of decision making by expert behavioral clinicians who employ DTE in the treatment of PTSD. Eighteen psychologists, who are recognized nationally for their use of DTE with PTSD (as well as their training of interns, students, and other professionals in the implementation of DTE), were mailed the decision making questionnaire. Eleven, or 61%, were returned.

Results

Overall, the respondents reported using multiple sources of assessment data in making decisions about DTE treatment. Ninety-one percent of the experts relied on the clinical interview in deciding whether to use DTE. Sixty-four percent utilized information from a psychosocial history, mental status exam, and inquiries into medical condition. Thirty-three percent used data obtained from psychophysiological assessments, and/or the MMPI. Information deemed most critical to obtain from these various sources included: concise descriptions of traumatic events, ruling out of concurrent psychiatric disorders and medical problems, adequate patient motivation and potential for compliance, and patient report of cue-specific arousal. One of the more significant findings of the present study is the experts' report that, over the span of their careers, DTE was employed in only 58% of the PTSD cases encountered. It is important to note, however, that the use of DTE ranged considerably in this regard; 0% to 100%.

Factors which dissuaded the expert clinicians from using DTE included: Marked psychological impairment (e.g., co-morbidity involving psychosis, poor cognitive functioning, and depression; 91% of respondents); concurrent character or substance abuse disorder (27%); treatment noncompliance (27%) inability to image (27%); unresolved life crises (18%); and poor physical health (18%). Previous failure with exposure treatment, minimal re-experiencing symptoms reported, and active compensation-seeking were also cited by single respondents as reasons for ruling out DTE treatment. Relatedly, the respondents reported the following patient characteristics which *may* rule out the use of DTE (or lead them to use DTE with caution): a history of impulsivity or suicidality (58%); personality disorders, particularly antisocial and borderline personality disorder (33%); and patient reluctance or defensiveness (17%).

Discussion

The results from the present study are important for behavior therapists who treat PTSD patients. First, DTE is clearly not considered appropriate for all PTSD cases. For example, stress inoculation training, supportive psychotherapy were alternatives noted. The decision to employ DTE is commonly based on information obtained *via* clinical interview and psychosocial history. Patients need to meet a fairly rigorous set of criteria. The ideal exposure candidate can provide a concise description of the traumatic event(s), has no debilitating concurrent diagnosis (psychiatric, Axis I or II; or medical, e.g., heart disease), possesses adequate motivation for change, and has demonstrable psychophysiological reactivity to specific, re-experienced, traumatic memories. Conversely, unsuitable patients possess characteristics which could interfere with the boundary conditions of the exposure method (e.g., poor ability to imagine, inability to tolerate intense arousal) or lead to poor compliance and/or treatment termination.

Figure 1 depicts a decision making tree which incorporates the

[1] *Available from the first author.*

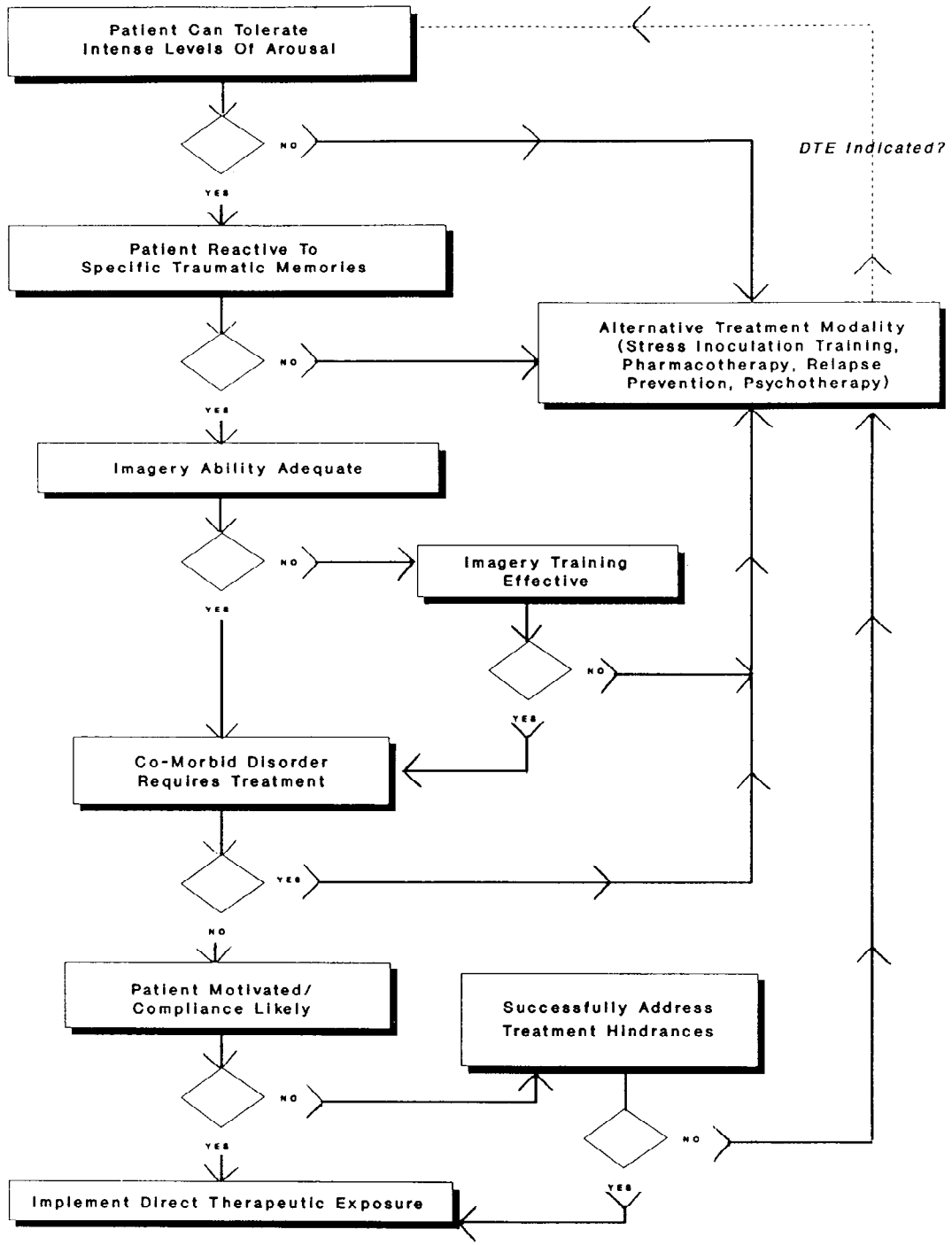

FIG 1 Decision Tree for the Use of DTE in the Treatment of PTSD

various factors deemed critical to decision making about DTE. The reader should keep in mind that this model is based on the expert respondents' answers to the questions posed to them; the decision tree, in this regard, is not theoretically derived, and is intended for heuristic purposes. The assumptions are, however, that a detailed psychological assessment has been completed (see Litz, Penk, Gerardi, & Keane, in press), the patient is seeking assistance, and that there is a sound therapeutic alliance (Fairbank & Brown, 1987). The decision tree is intended to provide the clinician with a series of sequential questions that they should pose about prospective PTSD patients. Thus, for example, the therapist should first ask themselves whether a patient can tolerate intense levels of arousal, (e.g., for medical reasons) and then continue down the tree.

The present study produced clinically useful findings, and also suggested directions for further empirical efforts. Future research on DTE decision-making might also entail obtaining information from a larger and more mainstream clinician group, that is, behavior therapists in general, in order to sample from a sizable and more representative population. Important information can also be obtained from using more realistic or

analog methods, rather than a questionnaire format. Written PTSD case vignettes or videotaped PTSD case interviews could be reviewed by behavior therapists who are asked for their judgments about the appropriateness of DTE.

Research is also needed on matching patient characteristics with treatment modalities in the treatment of PTSD. For example, it is important to identify the patient factors that are associated with success or failure when using exposure based therapy as opposed to a skills training approach, supportive psychotherapy, etc. Finally, future studies should identify *therapist* factors which might influence the decision making process. Several of the therapist factors which may be relevant in terms of judgments about the use of DTE are: coping resources (e.g., ability to tolerate intense arousal), level of expertise, and confidence in the theoretical underpinnings of the technique. Future studies can help identify therapist variables which are critical in the use of exposure based therapies.

This study represents an initial step toward elucidating the factors that are important in deciding whether to employ DTE with PTSD patients. Explicating these decision making guidelines will assist behavior therapists in their treatment selection with traumatized patients. Information of this nature is essential for providing these patients with appropriate and maximally effective treatments.

References

Boudewyns, P. A., & Shipley, R. H. (1983). *Flooding and Implosive therapy*. New York: Plenum Press.

Fairbank, J. A. (1989). Chronic combat-related post-traumatic stress disorder. In A. Nezu and C. Nezu (Eds.). *Clinical decision making in behavior therapy: A problem solving perspective* (pp. 297–319) Champaign, Il: Research Press.

Fairbank, J. A., & Brown, T. A. (1987). Current behavioral approaches to the treatment of post-traumatic stress disorder. *the Behavior Therapist, 10,* 57–64.

Fairbank, J. A., & Keane, T. M. (1982). Flooding for combat-related stress disorders: Assessment of anxiety reduction across traumatic memories. *Behavior Therapy, 13,* 499–510.

Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of post-traumatic stress disorder in Vietnam combat veterans. *Behavior Therapy, 20,* 245–260.

Keane, T. M., Fairbank, J. A., Caddell, J. M., Zimering, R. T., & Bender, M. E. (1985). A behavioral approach to assessing and treating post-traumatic stress disorder in Vietnam veterans. In C. R. Figley (ed.), *Trauma and its wake* (pp. 257–294). New York: Brunner/Mazel.

Keane, T. M., & Kaloupek, D. G. (1982). Imaginal flooding in the treatment of a post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 50,* 138–140.

Litz, B. T., Penk, W. E., Gerardi, R. J., & Keane, T. M. (in press). The assessment of post-traumatic stress disorder. In P. A. Saigh (Ed.), *Post-traumatic stress disorder: A behavioral approach to assessment and treatment.* New York: Pergamon Press.

Preparation of this research was supported by the National Center For PTSD. Requests for reprints should be sent to Brett T. Litz, Ph.D., National Center for PTSD, Behavioral Sciences Division, 116-B, Boston Veterans Affairs Medical Center, 150 S. Huntington, Boston, MA 02130. We would like to thank Dr. Steve Lancey, Beth Cahoon, Valerie Monaco, and Brian Marx for their help in the preparation of this manuscript.